

**Title 8, California Code of Regulations  
Chapter 4.5, Division of Workers' Compensation  
Subchapter 1  
Administrative Director – Administrative Rules**

Plain Text is Emergency Regulation Proposed for Permanent Adoption,  
Deletions from the codified emergency regulatory text are indicated by strike-through, thus: ~~deleted language~~.

Additions to the codified emergency regulatory text are indicated by underlining, thus: underlined language.

Deletions from the amended regulatory text, as proposed on January 12, 2004, are indicated by double strike-through underline, thus: ~~deleted language~~.

Additions to the amended regulatory text, as proposed on January 12, 2004, are indicated by a double underline, thus: added language.)

Deletions from the amended regulatory text, as proposed on March 18, 2004, are indicated by italics with double strike-through double under-line, thus: ~~*deleted language*~~.

Additions to the amended regulatory text, as proposed on March 18, 2004, are indicated by a dotted underline, thus: added language.

**Format for this amended regulatory text proposed 4/13/2004:**

Deletions are indicated by bold double strike-through in Arial font, thus: ~~**deleted language**~~.

Additions are indicated by bold double underline Arial font, thus: **added language**.

---

**Changes Related to the Effective Date:**

**Article 5.3**

**Official Medical Fee Schedule — ~~Services Rendered after January 1, 2004~~**

**Physician Services Rendered on or after July 1, 2004.**

**Inpatient Hospital Services for Services Rendered for an Admission with Date of Discharge on or after July 1, 2004.**

**Outpatient Services Rendered on or after July 1, 2004.**

**Pharmacy Services Rendered after January 1, 2004**

**Pathology and Laboratory Services Rendered after January 1, 2004**

**Durable Medical Equipment, Prosthetics, Orthotics, Supplies Services after January 1, 2004**

**Ambulance Services Rendered after January 1, 2004**

**Section 9789.10. Physician Services - Definitions.**

(a) "Basic value" means the unit value for an anesthesia procedure that is set forth in the

Official Medical Fee Schedule 2003.

- (b) “CMS” means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.
- (c) “Conversion factor” or “CF” means the factor set forth below for the applicable OMFS section:

Evaluation and Management	\$8.50
Medicine	\$6.15
Surgery	\$153.00
Radiology	\$12.50
Pathology	\$1.50
Anesthesia	\$34.50

- (d) “CPT<sup>®</sup>” means the procedure codes set forth in the American Medical Association’s Physicians’ Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association, or the Physicians’ Current Procedural Terminology (CPT) 1994, copyright 1993, American Medical Association.
- (e) “Medicare rate” means the physician fee schedule rate derived from the Resource Based Relative Value Scale and related data, adopted for the Calendar Year 2004, published in the Federal Register on January 7, 2004, Volume 69, No. 4, pages 1117 through 1242 (CMS-1372-IFC), as amended by CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 105 (February 20, 2004). ~~November 7, 2003, Volume 68, No. 216, pages 63262 through 63386 as “Addendum B,” which is incorporated by reference.~~ The Medicare rate for each procedure is derived by the Administrative Director utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor of 1.063.
- (f) “Modifying units” means the anesthesia modifiers and qualifying circumstances as set forth in the Official Medical Fee Schedule 2003.
- (g) “Official Medical Fee Schedule” or “OMFS” means Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 – ~~9789.110~~ **9789.111**), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600.
- (h) “Official Medical Fee Schedule 2003” or “OMFS 2003” means the Official Medical Fee Schedule incorporated into Section 9791.1 in effect on December 31, 2003, which consists of the OMFS book revised April 1, 1999 and as amended for dates of service on or after July 12, 2002.
- (i) “Percentage reduction calculation” means the factor set forth in Table A for each procedure code which will result in a reduction of the OMFS 2003 rate by 5%, or a lesser percent so that the reduction results in a rate that is no lower than the Medicare rate.

- (j) “Physician service” means professional medical service that can be provided by a physician, as defined in Section 3209.3 of the Labor Code, and is subject to reimbursement under the Official Medical Fee Schedule. For purposes of the OMFS, “physician service” includes service rendered by a physician or by a non-physician who is acting under the supervision, instruction, referral or prescription of a physician, including but not limited to a physician assistant, nurse practitioner, clinical nurse specialist, and physical therapist.
- (k) “RVU” means the relative value unit for a particular procedure that is set forth in the Official Medical Fee Schedule 2003.
- (l) “Time value” means the unit of time indicating the duration of an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

**Section 9789.11. Physician Services Rendered ~~After January 1, 2004, on or after July 1, 2004.~~**

(a) Except as specified below, or otherwise provided in this Article, the ground rule materials set forth in each individual section of the OMFS 2003 are applicable to physician services rendered ~~after January 1, 2004, on or after July 1, 2004.~~

(1) The OMFS 2003’s “General Information and Instructions” section is not applicable. The “General Information and Instructions, Effective for Dates of Service ~~after January 1, 2004 on or after July 1, 2004,~~” are incorporated by reference and will be made available on the Division of Workers’ Compensation Internet site ([http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm)) or upon request to the Administrative Director at:  
Division of Workers’ Compensation (Attention: OMFS – Physician Services)  
P.O. Box 420603  
San Francisco, CA 94142

(b) For physician services rendered ~~after January 1, 2004 on or after July 1, 2004~~ the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. The reduction rate for each procedure is set forth as the adjustment factor in Table A. Reimbursement for procedures that are reimbursed under OMFS 2003 at a rate below the Medicare rate will not be reduced.

(c) Table A, “OMFS Physician Services Fees for Services Rendered ~~after January 1, 2004,~~ on or after July 1, 2004,” which sets forth each individual procedure code

with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference. Table A may be obtained from the Division of Workers' Compensation Internet site ([http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm)) or upon request to the Administrative Director at:

Division of Workers' Compensation (Attention: OMFS – Physician Services)  
P.O. Box 420603  
San Francisco, CA 94142

- (d) (1) Except for anesthesia services, to determine the maximum allowable reimbursement for a physician service rendered ~~after January 1, 2004~~ on or after July 1, 2004 the following formula is utilized:  $R\text{VU} \times \text{conversion factor} \times \text{percentage reduction calculation} = \text{maximum reasonable fee before application of ground rules}$ . Applicable ground rules set forth in the OMFS 2003 and the "General Information and Instructions, Effective for Dates of Service ~~after January 1, 2004,~~ on or after July 1, 2004," are then applied to calculate the maximum reasonable fee.
- (2) To determine the maximum allowable reimbursement for anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, the following formula is utilized:  $(\text{basic value} + \text{modifying units (if any)} + \text{time value}) \times (\text{conversion factor} \times .95) = \text{maximum reasonable fee}$ .
- (e) The following procedures in the Pathology and Laboratory section (both professional and technical component) will be reimbursed under this section: CPT Codes 80500, 80502; 85060 through 85102; 86077 through 86079; 87164; and 88000 through 88399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50, including but not limited to ~~The following procedure codes in the Pathology and Laboratory section are reimbursed in accordance with subdivision Section 9789.50: CPT Codes 80002 through 80440; 81000 through 85048; 85130 through 86063; 86140 through 87163; 87166 through 87999; and 89050 through 89399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50.~~

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

**Section 9789.20. General Information for Inpatient Hospital Fee Schedule –**  
**Discharge ~~after January 1, 2004~~ on or after July 1, 2004.**

- (a) This Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule covers charges made by a hospital for inpatient services provided by the hospital.
- (b) Charges by a hospital for the professional component of medical services for physician services shall be paid according to Sections 9789.10 through 9789.11.
- (c) Sections 9789.20 through 9789.24 shall apply to all bills for inpatient services with a date of discharge ~~after January 1, 2004,~~ on or after July 1, 2004, ~~except that~~

~~Sections 9789.20 through 9789.22 will not apply to any bills for medical services with a date of admission on or before December 31, 2003. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004.~~ Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

- (d) The Inpatient Hospital Fee schedule shall be adjusted to conform to any relevant changes in the Medicare payment schedule, including mid-year changes no later than 60 days after the effective date of those changes. Updates ~~will~~ shall be posted on the Division of Workers' Compensation webpage at [http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm). The annual updates to the Inpatient Hospital Fee schedule ~~will~~ shall be effective every year on October 1.
- (e) Any document incorporated by reference in Sections 9789.20 through 9789.24 is available from the Division of Workers' Compensation Internet site ([http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm)) or upon request to the Administrative Director at:  
Division of Workers' Compensation (Attention: OMFS)  
P.O. Box 420603  
San Francisco, CA 94142

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

#### **Section 9789.32. Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability.**

- (a) Sections 9789.30 through 9789.36~~8~~ shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered ~~after January 1, 2004 on or after July 1, 2004.~~ For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10040-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if:
  - (1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or,
  - ~~(2) the item is assigned to the same APC as the emergency room visit or surgical procedure and has a status indicator H or~~

- ~~(2)(3)~~ the item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned Status Code G, H or K.

Payment for other services furnished in conjunction with a surgical procedure or emergency room visit shall be in accordance with subdivision (c) of this Section.

- (b) Sections 9789.30 through 9789.368 apply to any hospital outpatient department as defined in Section 9789.30(n) and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act and any ASC as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis.
- (c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined as follows:
- ~~(1) The maximum allowable fees for the technical component of the diagnostic services shall be determined according to Section 9789.10 and Section 9789.11.~~
- ~~(2)(1)~~ The maximum allowable fees for ~~the professional component of~~ medical services ~~that are not included in the APC payment rate for emergency room visits and surgical procedures, and~~ which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.
- ~~(3)(2)~~ The maximum allowable fees for organ acquisition costs and corneal tissue acquisition costs shall be based on the documented paid cost of procuring the organ or tissue.
- ~~(4)(3)~~ The maximum allowable fee for drugs ~~not otherwise covered by a Medicare fee schedule payment for facility service~~ shall be 100% of the fee prescribed by Medical pursuant to Labor Code Section 5307.1 subdivision (a), or, where applicable, Section 9789.40.
- ~~(5)(4)~~ The maximum allowable fee for clinical diagnostic tests shall be determined according to Section 9789.50.
- ~~(5)~~ The maximum allowable fees for non-surgical, ~~the technical component of the diagnostic~~ ancillary services with a status code indicator "X" shall be determined according to Section 9789.10 and Section 9789.11.

- (6) The maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60.
- (7) The maximum allowable fee for ambulance service shall be determined according to Section 9789.70.
- (d) Only hospitals may charge or collect a facility fee for emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(n) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis.
- (e) Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, Section 9789.31(a)(5), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.
- (f) Critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.
- (g) Out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.
- (h) Hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this Section shall present with their bill the name and physical address of the facility, the facility's Medicare Provider Number or UPIN (or, in the absence of the Medicare number, the OSHPD Facility Number). The bill shall include the dates of service, the diagnosis and current HCPCS ~~procedure~~ codes and charges for each billed service, including HCPCS codes for any items and services that are packaged into the APC payment for a significant procedure. ~~and the applicable APC codes.~~

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

**Section 9789.33. Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee.**

- (a) For Services rendered ~~after January 1, 2004~~ **on or after July 1, 2004**, the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or at an ambulatory surgical center shall be determined based on the following. The 1.22 factor shall be used in lieu of an additional payment for high cost outlier cases.
  - (1) ~~Procedure codes~~ CTP codes 99281-99285 and CPT codes 10040-69990

with status code indicators “S”, “T”, “X” or “V”:

***(APC relative weight x \$52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.22***

(A) Table A in Section 9789.34 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for ASCs and non-listed hospitals can be determined as follows:

***APC relative weight x adjusted conversion factor x 1.22***

(B) Table B in Section 9789.35 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for the listed hospitals can be determined as follows:

***APC relative weight x adjusted conversion factor x 1.22***

- (2) Procedure codes for drugs and biologicals with status code indicator “G”:

***APC payment rate x 1.22***

- (3) Procedure codes for devices with status code indicator “H”:

***Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.***

- (4) Procedure codes for drugs and biologicals with status code indicator “K”:

***APC payment rate x 1.22***

- (b) Alternative payment methodology. In lieu of the maximum allowable fees set forth under (a), the maximum allowable fees for a facility meeting the requirements in subdivisions (c)(1) through (c)(5) will be determined as follows:

- (1) Standard payment:

- (A) ~~Procedure codes~~ CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators “S”, “T”, “X” or “V”:

***(APC relative weight x \$52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.20***



- (B) Procedure codes for drugs and biologicals with status code indicator “G”:

*APC payment rate x 1.20*

- (C) Procedure codes for devices with status code indicator “H”:

*Documented paid costs, net of discounts and rebates, plus 10% **not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.***

- (D) Procedure codes for drugs and biologicals with status code indicator “K”

*APC payment rate x 1.20*

~~(E) *Procedures codes for surgical procedures with status code indicator “X” when no APC payment is made for a procedure with status code indicator “S”, “T”, or “V”.*~~

~~*APC relative weight x adjusted conversion factor x 1.20*~~

- (2) Additional payment for high cost outlier case:

*[(Facility charges x cost-to-charge ratio) – (standard payment x 2.6)] x .50*

- (3) In determining the additional payment, the facility’s charges and ~~standard~~ payment for devices with status code indicator “H” shall be excluded from the computation.

- (c) The following requirements shall be met for election of the alternative payment methodology:

- (1) A facility seeking to be paid for high cost outlier cases under subdivision 9789.33(b) must file a written election using DWC Form 15 “Election for High Cost Outlier,” contained in Section 9789.37 with the Division of Workers’ Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128. The form must be filed post-marked by March 1 of each year and shall be effective for one year commencing with services furnished on or after April 1 of the year in which the election is made.

- (2) The maximum allowable fees applicable to a facility that does not file a timely election satisfying the requirements set forth in this subdivision and Section 9789.37 shall be determined under subdivision (a).

- (3) The maximum allowable fees applicable to a hospital that does not participate under the Medicare program shall be determined under subdivision (a).

- (4) The cost-to-charge ratio applicable to a hospital participating in the Medicare program shall be the hospital's cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments under 42 C.F.R. § 419.43(d), which is incorporated by reference, as contained in Section 9789.38 Appendix X. The cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year the election is filed shall be included on the hospital's election form.
- (5) The cost-to-charge ratio applicable to an ambulatory surgery center shall be the ratio of the facility's total operating costs to total gross charges during the preceding calendar year. Total Operating Costs are the direct costs incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs. Total gross charges are defined as the facility's total usual and customary charges to all patients and third-party party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care. The facility's election form, as contained in Section 9789.37 shall include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. The facility's election form shall further include the facility's total operating costs during the preceding calendar year, the facility's total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to the Division of Workers' Compensation's audit.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website at <http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms> or upon request to the ~~Administrative Director at:~~ Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box ~~420603~~8888, San Francisco, CA 941~~4228~~.
- (6) Before April 1 of each year the AD shall post a list of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The list shall be posted on the Division of Workers' Compensation website: [http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm) or is available upon request to the ~~Administrative Director at:~~ Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box

~~420603~~ 8888, San Francisco, CA 941~~4228~~.

- (d) Any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. Such request shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the cost-to-charge ratio or reaffirm the published cost-to-charge ratio.
- ~~(d)~~(e) The OPPS rules in 42 C.F.R. § 419.44 regarding reimbursement for multiple procedures are incorporated by reference as contained in Section 9789.38 Appendix X.
- ~~(e)~~(f) The OPPS rules in 42 C.F.R. §§ 419.62, 419.64, and 419.66 regarding transitional pass-through payments for innovative medical devices, drugs and biologicals shall be incorporated by reference, as contained in Section 9789.38 Appendix X, except that payment for these items shall be in accordance with subdivisions (a) or (b) as applicable.
- ~~(f)~~(g) The payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b)(1)-(12), which is incorporated by reference as contained in Section 9789.38 Appendix X.
- (h) The maximum allowable fee shall be determined without regard to ~~In addition, all of the cost items specified in 42 C.F.R. § 419.2(c)1-6 (1), (2), (3), (4), and (6), as contained in Section 9789.38 Appendix X, are included in the maximum allowable payment rate and are incorporated by reference as contained in Section 9789.38 Appendix X. Cost item set forth at 42 C.F.R. §419(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(2). Cost items set forth at 42 C.F.R. §419(c)(7) and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(3).~~
- ~~(g)~~(i) The maximum allowable fees shall be determined without regard to the provisions in 42 C.F.R. § 419.70.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

### **Section 9789.111. Effective Date of Fee Schedule Provisions**

**(a) The OMFS regulations for Physician Services (Sections 9789.10-9789.11) are effective for services rendered on or after July 1, 2004. Services rendered after**

January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004.

(b) The OMFS regulations for Inpatient Services (Sections 9789.20-9789.24) are effective for inpatient hospital admissions with dates of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004. Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

(c) The OMFS regulations for Outpatient Services (Sections 9789.30-9789.38) are effective for services rendered on or after July 1, 2004. Services rendered after January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004.

(d) The OMFS regulation for pharmacy (Section 9789.40) is effective for services rendered after January 1, 2004.

(e) The OMFS regulation for Pathology and Laboratory (Section 9789.50) is effective for services rendered after January 1, 2004.

(f) The OMFS regulation for Durable Medical Equipment, Prosthetics, Orthotics, Supplies (Section 9789.60) is effective for services rendered after January 1, 2004.

(g) The OMFS regulation for Ambulance Services is effective for services rendered after January 1, 2004.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

---

#### **Changes Related to the General Information and Instructions (8 CCR §9789.11(a)(1))**

[Section 9789.11(a)(1) incorporates by reference the “General Information and Instructions”. The title of this document and portions of the text need to be updated to reflect the clarification made to the physician fee schedule regulations that the effective date of the permanent regulation is for services rendered on or after July 1, 2004. Changes are made as follows, text is excerpted in the interests of economy.]

#### **General Information and Instructions (8 CCR §9789.11(a)(1)) Effective for Dates of Service ~~after January 1, 2004~~ on or after July 1, 2004.**

[Page 1, Authority, 2<sup>nd</sup> paragraph]

This revision to the Official Medical Fee Schedule sets forth changes to the instructions and ground rules adopted by the Administrative Director. The amendments to the Official Medical Fee schedule contained in this revision are effective for services rendered ~~after January 1,~~

~~2004~~on or after July 1, 2004. You will need to consult the applicable prior schedule for services that were provided on or before December 31, 2003=or after January 1, 2004 but before July 1, 2004.

[Page 2, Services Covered, middle of page left column]

NOTE: THE FOLLOWING PROCEDURES IN THE SPECIAL SERVICES AND REPORTS SECTION OF THIS BOOK WILL NOT BE VALID FOR SERVICES RENDERED ~~AFTER JANUARY 1, 2004~~ on or after July 1, 2004.

99000	99001
99002	99017
99019	99020
99021	99026
99027	

[Page 2, Format, first sentence]

The physician services section of the Official Medical Fee Schedule, effective ~~after January 1, 2004~~ on or after July 1, 2004, consists of six major sections.

[Page 3, General Instructions Fee Computation and Billing Procedures, first-third paragraphs]

Under Title 8, California Code of Regulations Section ~~9789.11~~ 9788.11, the maximum allowable fee for physician services rendered ~~after January 1, 2004~~ on or after July 1, 2004 is the amount set forth in the Official Medical Fee Schedule in effect on December 31, 2003 reduced by five (5) percent. However, individual procedure codes that are reimbursed under the Official Medical Fee Schedule in effect on December 31, 2003 at a rate that is ~~between~~ greater than 100% and 105% of the current Medicare rate will be reduced ~~between zero and~~ up to 5% so that the reimbursement will not fall below the Medicare rate.

To determine the maximum allowable reimbursement for a physician service rendered ~~after January 1, 2004~~ on or after July 1, 2004 the following formula is utilized: Relative Value Unit × Conversion Factor × Percentage Reduction Calculation = Maximum Reasonable Fee before application of ground rules. Applicable ground rules set forth in the Official Medical Fee Schedule in effect on December 31, 2003 are then applied to calculate the maximum reasonable fee.

To determine the maximum allowable reimbursement for services involving the administration of anesthesia (CPT Codes 00100 through 01999) rendered ~~after January 1, 2004,~~ on or after July 1, 2004, the following formula is utilized: (basic value + modifying units (if any) + time value) × (conversion factor × .95) = maximum reasonable fee.

---

#### Changes Related to Table A, OMFS Physician Fees:

[Section 9789.11 (c) The header title of the Table A, incorporated by reference, is updated as follows; in the March 30, 2004 proposal it was titled: “2004 OMFS Fees revised”.]

**OMFS Physician Services Fees for Services Rendered on or after July 1, 2004**

**Section 9789.11 (c)** [Corrections to codes 97802 and 97803]

FS Section	PROCEDURE MOD	DESCRIPTION	RVU	CF	% Reduction	Maximum Reimbursable Fee
Physical Medicine	97802	Cupping	3.1	6.15	<del>0.4%</del> <u>5%</u>	<del>49.00</del> <u>18.11</u>
		Moxibustion In				
Physical Medicine	97803	Acupuncture	3.1	6.15	<del>0.4%</del> <u>5%</u>	<del>49.00</del> <u>18.11</u>

**Section 9789.11 (c)** [Corrections to various codes to correct the March 30, 2004 proposed Table A which inadvertently used 1.06 GPCI instead of the 1.063 GPCI when calculating the Medicare rates.]

[Table A Corrections attached. Note: the OMFS 2003 Allowed column is NOT proposed to be part of the adopted regulatory text, but is for informational purposes in this proposal. The data in the other columns is all proposed to replace those elements for the specified codes in the adopted Table A.]